

CITY OF INDIANAPOLIS
DIRECT PAYMENT VOUCHER
For City Department Use Only

CHECK NO. _____

VENDOR NO. _____

NOTE: SHADED AREAS FOR CONTROLLER'S
USE ONLY

Due Date: _____

PAY TO: _____

Fund/Subfund No. _____

Subfund Name _____

Division Name _____

VOUCHER NO. _____

LINE # A	TC	DOCUMENT	REF	DESCRIPTION					AMOUNT	
LINE # B	INDEX CODE	SUBJECT	USER CODE	GRANT	DETAIL	PROJECT	DETAIL	GL	SUBSIDIARY	
1 A										
1 B										
2 A										
2 B										
3 A										
3 B										
4 A										
4 B										
5 A										
5 B										
6 A										
6 B										
7 A										
7 B										
8 A										
8 B										
9 A										
9 B										
10 A										
10 B										

#VALUE!

HASH TOTAL

VOUCHER TOTAL \$

-

I certify that the within bill is true and correct; that the supplies and materials therein itemized and for which charge is made were ordered by me and were necessary to public business; that each and every item has been delivered to me at prices mentioned, and was in accordance with contract, except

AUTHORIZED SIGNATURE / DATE
ALLOWED _____ 20____

AUTHORIZED SIGNATURE

I have examined the within claim and hereby certify that it is in proper form, is duly authorized as required by law, is based upon contract or statutory authority and is apparently correct.

CONTROLLER

Approved by the State Board of Accounts
For City of Indianapolis 1985. Form C-1 (1-86)

Note: Invoices will only be paid when this section is completed and returned to:

City of Indianapolis
200 E Washington St, Ste 801
Indianapolis, IN 46204

- 1.) **CLAIMANT:** Provide vendor name that check should be made out to and address **where check is to be mailed.**
- 2.) **NATURE OF CLAIM:** Itemize total claim amount by type of item (s) or service (s) provided. If invoice provides detail, include a general description. Amount of claim must equal amount of invoice. Do not include State Sales Tax or Federal Tax ----- Exemption Number:

003157 202 001 0

Attach invoices in duplicate.

- 3.) **CERTIFICATION:** Provide vendor division or subsidiary name if different than name to appear on check. A certification signature is required by an authorized company representative. Indicate title of representative and date of signature.

1.) **CLAIMANT:** Name _____
Address _____
City _____ State _____ Zip _____

2.) NATURE OF CLAIM

ITEM NO.	DATE	DESCRIPTION OF CLAIM	AMOUNT
TOTAL			-

3.) CERTIFICATON:

I hereby certify that the foregoing account is just and correct, that the amount claimed is legally due, after allowing all just credits, and that no part of the same has been paid.

VENDOR DIVISION/SUBSIDIARY

Date _____
xx/xx/xx

Authorized Company Representative	Title
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